Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CENTRE FOR NEURO SKILLS
2658 MOUNT VERNON AVENUE
BAKERSFIELD CA 93306

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1283-01

MFDR Date Received
December 2, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Negotiated rate effective 2-1-04. Payments I the amount of $487 Per Diem were received through 5-15-05. Requestor's amount billed is fair and reasonable for the services provided to patient, [injured employee]. These reasonable charges were agreed to by the carrier, and employer and under the agreement has been paid since 1994."

Amount in Dispute: $13,636.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor charged a fee of $487 per day for its services and treatment of the Claimant. The services allegedly being provided and billed under CPT Code 97799 do not have an established Division maximum allowable reimbursement. Because there is not a maximum allowable reimbursement for the services, the amount to be reimbursed is the fair and reasonable amount for the services provided. However, and in order to determine the fair and reasonable amount, the Requestor is required to submit proper documentation." "Requestor did not provide proper supporting documentation. Their documentation generally describes a month of alleged activities; however, it does not adequately describe the day-to-day care and activities of the Claimant and how Requestor arrived at $487.00 per day to care for and provide a living environment for the Claimant." "Respondent relied upon its own methodology to determine a fair and reasonable rate of reimbursement. Respondent conducted a survey of the metropolitan area in which the services were provided, including a specific bid from a competing provider, and as a result determined that the reimbursement rate of $200 per day, was a fair and reasonable amount for medical services." "Requestor argued that they had a contract with Respondent which stated that a fee of $487 would be paid for each day the claimant remained at Requestor's facility. However, Requestor has not provided any contract signed by Respondent. Additionally, please see the attached Affidavit of Cindy Gowing which confirms that Respondent has consistently maintained that it would continue to be responsible for the care and treatment of the Claimant as provided by the Texas Workers' Compensation Act and not due to any alleged and unseen contract." "Further, please see attached internal communication from Requestor admitting that there was no negotiated contract with Respondent regarding the fees for treatment of the Claimant. Additionally, Requestor failed to preauthorize the medical services."

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2010 through February 28, 2010	Assisted Living Services – CPT Code 97799	$13,636.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.4 sets out the procedures for timely filing to the insurance carrier.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 27, 2011. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 937 – Service(s) are denied based on HB& provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - W1 – Workers Compensation State Fee Schedule adjustment.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §129.4 for timely filing to the insurance carrier?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307 requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Review of the submitted documentation shows that the requestor has met the requirements of the rule.
2. Rule 102.4(h), titled General Rules for Non-Commission Communication, states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
3. Section 408.027(a) of the Labor Code states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
4. Thorough review of the documentation submitted by the requestor finds that the requestor has not submitted documentation to support that the disputed dates of service were timely filed. Therefore, reimbursement cannot be recommended.

Conclusion

The Division concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		June 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.